

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395795	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 04/10/2023
NAME OF PROVIDER OR SUPPLIER: LAFAYETTE MANOR, INC. STATE LICENSE NUMBER: 120202			STREET ADDRESS, CITY, STATE, ZIP CODE: 147 LAFAYETTE MANOR ROAD UNIONTOWN, PA 15401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	<p>INITIAL COMMENT</p> <p>Findings of an abbreviated survey completed on April 10, 2023, at Lafayette Manor, identified no deficient practice, related to the reported complaint allegations, under requirements of 42 CFR Part 483, Subpart B Requirements for Long Term Care Facilities and 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations, as they relate to the health portion of the survey process.</p>		F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.



Certified End Page

LAFAYETTE MANOR, INC.

STATE LICENSE NUMBER: 120202

SURVEY EXIT DATE: 04/10/2023

**I Certify This Document to be a True and Correct Statement of Deficiencies and
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink that reads "Jeane Parisi".

Jeane Parisi
Deputy Secretary for Quality Assurance

A handwritten signature in black ink that reads "Debra L. Bogen MD".

Debra L. Bogen, MD, FAAP
Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY